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Employee

Benefit Booklet

July, 1991
(Revised July, 1992)

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ELIGIBILITY & ENROLLMENT

EMPLOYEES

ELIGIBILITY

1. **Full-Time Employees**

An employee for the Employer who as a(n):

INSTRUCTOR, works a minimum of 9 Months and 177 Contract Days;

CLASSIFIED EMPLOYEE, regularly works 40 or more hours per week;

ADMINISTRATION EMPLOYEE, regularly works 40 or more hours per week; or

PROGRAM/TECHNICAL EMPLOYEE, regularly works 40 or more hours per week;

will be eligible to participate in the Plan as a Full-Time Employee **provided** he is a resident of the United States.

2. **Part-Time Employees**

An Employee for the Employer who, as an:

INSTRUCTOR, works less than 177 Contract Days; or

ADMINISTRATION EMPLOYEE, regularly works less than 40 Hours per week;

will be eligible to participate in the Plan as a Part-Time Employee **provided** he is a resident of the United States. Further, an Eligible Part-Time Employee is required to pay the monthly cost for coverage. It is the sole responsibility of the Part-Time Employee to make payments in full by the date required.

An Eligible Employee's participation in the Plan is subject to a waiting period from the date of hire or commencement of the applicable full-time or part-time employment until the end of the month.

An Employee's Eligibility Date is the next day following the completion of the waiting period. If an eligible employee is hired on the first of the month, coverage should commence that day. Further an Eligible Part-time Employee is required to pay the total monthly cost for coverage and to make that payment to the college by the 25th of each month. It is the sole responsibility of the Part-time Employee to make payments in full by the date required.

Plan Enrollment

An Eligible Employee who elects to participate in the Plan, must complete, sign and return the provided "Enrollment Form" to the Employer within thirty (30) days of the Eligibility Date.

ELIGIBLE RETIREES

Eligibility

An Employee who: has been employed by the Employer; becomes retired from service or disabled; and is receiving retirement or disability benefits for service with the Employer; will be deemed to be an Eligible Retiree on the first day of the month following the date active service with the Employer ceases **provided** he is a resident of the United States. Further an Eligible Retiree is required to pay the total monthly cost for coverage and to make that payment to the college by the 25th of each month. It is the sole responsibility of the Retiree to make payments in full by the date required.

Plan Enrollment

An Eligible Retiree who elects to participate in the Plan, must complete, sign and return the provided "Enrollment Form" to the Employer within thirty (30) days of the Eligibility Date.

FAMILY DEPENDENTS

Eligibility

Eligible Family Dependents will be an Eligible Full-Time Employee's/Retiree's Spouse and each unmarried dependent child who is not yet Age 23 **provided** such Dependent is a resident of the United States.

Child, as used herein, shall also include: stepchild; adopted child (from the date of placement with the Employee/Retiree for purpose of legal adoption) - **except** when such child is adopted/placed with the Employee/Retiree for the purpose of legal adoption within 31 days of birth, then eligibility will commence from birth; and a child for whom the Employee/ Retiree is: the legal guardian **or** required to provide health coverage due to a Court Order.

No individual may be covered under this Plan as both an Employee/Retiree and a Dependent. If a husband and wife are both Eligible Employees/Retirees under the Plan, only one of them may cover their Eligible Dependents.

Mentally Retarded or Physically Handicapped Child: If an unmarried dependent child reaches Age 23 and is incapacitated and unable to be self-supporting by reason of mental retardation or physical handicap, then such child will continue to be an Eligible Dependent. **However**, the Employee/Retiree must provide the Plan with written evidence of such child's incapacity.

Plan Enrollment

If an Eligible Employee/Retiree has an Eligible Dependent(s) as of his Eligibility Date, such Dependent(s) will participate in the Plan when the Eligible Employee/Retiree completes, signs and returns the provided "Enrollment Form" for Family Coverage to the Employer within thirty (30) days of his Eligibility Date.

When a Covered Employee/Retiree acquires his first Eligible Dependent, he has sixty (60) days from the date of acquisition in which to enroll in Family Coverage.

A Covered Employee/Retiree does **not** have to enroll an Eligible Dependent acquired **after** the Effective Date of Family Coverage under the Plan. Further, the Retiree is required to pay the monthly cost for Dependent Coverage.

EFFECTIVE DATE OF COVERAGE

Employees

Coverage for an Eligible Employee who enrolls in the Plan will be effective on whichever of the following occurs first:

1. The Employee's Eligibility Date if he enrolls within thirty (30) days thereafter.

2. The first of the month following the date the Employee enrolls when he is a "Late Enrollee".

However, an Employee's coverage will not become effective if he is not Actively-At-Work on that date, but will be delayed until the date he returns to active full-time work.

Actively-At-Work, as used here, means the Employee is either at work **or** on a regular paid vacation or regular day-off from the Employer **provided** he was at work on the last preceding regular work day and he is not Totally Disabled.

Totally Disabled, as used herein, means the Employee, because of Illness or Injury, is under the care of a Physician and completely unable to perform the duties of his regular or customary occupation and is not performing any other work or engaged in any other occupation for wage or profit.

RETIREES

Coverage for an Eligible Retiree who enrolls in the Plan will be effective on whichever of the following occurs first

1. The Retiree's Eligibility Date if he enrolls within thirty (30) days thereafter.

2. The first of the month following the date the Retiree enrolls when he is a "Late Enrollee".

However, a Retiree's coverage will not become effective if he is Confined as a bed patient in a Hospital (or other facility) on that date, but shall be delayed until the date he is discharged.

FAMILY DEPENDENTS

When an Employee/Retiree enrolls in Family Coverage under the Plan as previously indicated, a Dependent's coverage will be effective on whichever of the following occurs later:

1. The Employee's/Retiree's effective date;

2. The date the Dependent is acquired;

3. With reference to a Child who is adopted by or placed with the Covered Employee/Retiree for the purpose of legal adoption within thirty-one (31) days of birth, then such Child will be effective on the date of birth. Further, if the natural mother of such Child does not have any other coverage, all pre-natal care and related pregnancy services, including delivery, will be deemed to be incurred by such Child and covered hereunder; or

4. The first of the month following the date the Employee/Retiree enrolls in Family Coverage for the Dependent who is a "Late Enrollee".

However, a Dependent's coverage will not become effective if he is Confined as a bed patient in a Hospital (or other facility) on that date, but will be delayed until the date he is discharged. This does not apply to a newborn Dependent Child **unless** the Employee/Retiree is not enrolled in Family Coverage as of the date of birth. Coverage for such child may be retroactive to the date of birth **provided** the Employee/ Retiree enrolls in Family Coverage within sixty (60) days of the date of birth.

DENTAL BENEFIT WAITING PERIOD

Although Dental coverage under the Plan becomes effective for an individual, as indicated above, certain Dental Services are subject to a waiting period before such services will be covered under the Plan. Dental Benefits will be effective on the next day following 240 consecutive days of continuous coverage under the Plan for the following Dental Services:

1. Inlays, Onlays or Crowns (Not part of a bridge);

2. Bridges, Removable or Fixed;

3. Dentures, Full or Partial.

TERMINATION OF GROUP COVERAGE

EMPLOYEES

Coverage for an Employee and/or his Dependent shall terminate on whichever of the following occurs first:

1. In the event the Employee fails to make any required contributions for his coverage when due, the Employee's coverage will automatically terminate at the end of the period for which contribution was made; unless due to clerical error whereupon past contributions may be paid to bring coverage current.

2. The last day of the month in which the Employee terminated employment. Termination of Employment, as used here, means cessation of active work due to lay-off, approved leave-of-absence, employee death, voluntary or involuntary resignation, or being pensioned.

3. The date this Plan terminates and is not replaced by another plan for the Employer.

4. The date maximum benefits for a Covered Individual have been fully discharged under the Plan.

5. The date the Covered Individual is no longer eligible.

RETIREES

Coverage for a Retiree and/or his Dependent shall terminate on whichever of the following occurs first:

1. The date the Retiree fails to submit, when due, the monthly payment required for coverage.
2. The date the Retiree becomes eligible to be covered under any other group health plan provided by another employer.

3. The date this Plan terminates and is not replaced by another plan for the Employer.

4. The date maximum benefits for a Covered Individual have been fully discharged under the Plan.

5. The date the Covered Individual is no longer eligible.

6. Death of the Retiree.

COBRA COVERAGE CONTINUATION PROVISIONS

QUALIFYING EVENTS

EMPLOYEES/RETIREES

If group coverage under the Plan terminates for the Employee/Retiree and his Dependent(s) due to the Employee's/Retiree's termination for any reason **except** when the Employee/Retiree is immediately entitled to Medicare (enrolled in Medicare) or voluntarily cancels coverage; or when the Employee is involuntarily terminated by the Employer for gross misconduct; then the Employee/Retiree qualifies for the Coverage Continuation Privilege.

FAMILY DEPENDENTS

If the Dependent's coverage under the Plan terminates due to: the Employee's/Retiree's death, divorce, legal separation or entitlement to Medicare (enrolled in Medicare); **or** the Dependent child is no longer eligible; then the Dependent(s) qualifies for the Coverage Continuation Privilege.

COBRA COVERAGE CONTINUATION PRIVILEGE

The Employee/Retiree and/or Dependent(s) who qualify may elect to continue coverage through payment of the Monthly COBRA Contribution to the Employer. The contribution is due the 25th of the prior month for which coverage is to be in force. However, there is a thirty (30) day Grace Period from the due date in which to submit the Monthly COBRA Contribution.

EMPLOYEES/RETIREES

Coverage continued under the Employee's/Retiree's privilege for himself and/or his Dependent(s) will terminate on whichever of the following occurs first:

1. The date the Employee/Retiree is covered under any group health plan that does not include a Pre-Existing Conditions clause which applies to either the employee/retiree or any covered dependent;

2. The date the Employee/Retiree becomes entitled to Medicare (enrolled in Medicare) Coverage;

3. The date the Employee/Retiree fails to pay, when due, the required monthly contribution to continue coverage;

4. The date eighteen (18) months have expired from the date group coverage terminated **unless** the Employee/Retiree or any covered dependent is determined to be disabled by the Social Security Administration (and to

have been so since group coverage terminated). In this case, the Employee/Retiree must notify the Employer in writing prior to the expiration of the initial eighteen months **in order to extend** this continuation privilege for up to an additional eleven (11) months or until the individual is no longer disabled, whichever occurs first.

5. The date of the Employee's/Retiree's death; or

6. The date this Plan is terminated and not replaced by another plan for the Employer.

The Employee/Retiree has the option to continue coverage for himself and/or his Covered Family Dependent(s) or to continue coverage **only** for the covered individual **affected** by either the pre-existing conditions clause (1) or determined to be disabled (4) as indicated above.

Family Dependents

Coverage continued under the Dependent's privilege will terminate on whichever of the following occurs first:

1. The date the Spouse and/or Dependent Child(ren) are covered under any group health plan that does not include a Pre-Existing Conditions clause which applies to any covered dependent;

2. The date the Dependent becomes entitled to Medicare (enrolled in Medicare) Coverage;

3. The date the Dependent fails to pay, when due, the required monthly contribution to continue coverage;

4. The date thirty-six (36) months have expired from the date the Dependent's group coverage terminated;

5. The date this Plan is terminated and not replaced by another plan for the Employer; or

6. The date a Dependent Child's coverage would normally have terminated due to a change in his eligibility status [the Dependent Child then qualifies to individually elect to continue coverage which would then be subject to termination as indicated in paragraphs 1 through 5 above].

If the Dependent is affected by more than one qualifying event, a second and separate election to continue coverage may be made. However, the Maximum duration for any one or combination of continuation privileges **cannot exceed** thirty-six (36) months from the date the original event occurred which terminated group coverage for the Dependent. Further, if any of the events occur as indicated in paragraphs 1 through 5 above, then continued coverage for the Dependent would terminate.

COBRA PRIVILEGE TIME LIMITS

Employees/Retirees

The Employee/Retiree and/or his Dependent(s) who qualify under the Employee's/Retiree's privilege, has various time limits in which to exercise this privilege and prevent forfeiture as follows:

1. A **60-Day Time Limit** from the date he receives Employer notification of this privilege in which to make application to the Employer to continue coverage;

2. A **45-Day Time Limit** from the date he has signed his application **before** the initial COBRA payment is due for the coverage period which encompasses the next day following group coverage termination and up to the application date; and

3. Thereafter, a **30-Day Time Limit** or Grace Period from the first of each COBRA Month in which to remit the COBRA Contribution.

Family Dependents

The Dependent has various time limits in which to exercise this privilege and prevent forfeiture as follows:

1. A **60-Day Time Limit** from the date the Employee/Retiree is Divorced, Legally Separated or entitled to Medicare (enrolled in Medicare) or the Dependent Child is no longer eligible, in which to notify the Employer that he is no longer eligible under the Plan;

2. A **60-Day Time Limit** from the date he receives the subsequent Employer notification of this privilege in which to make application to the Employer to continue coverage;

3. A **45-Day Time Limit** from the date he has signed his application **before** the initial COBRA payment is due for the coverage period which encompasses the next day following group coverage termination and up to the application date; and

4. Thereafter, a **30-Day Time Limit** or Grace Period from the first of each COBRA Month in which to remit the COBRA Contribution.

MEDICAL COVERAGE CONVERSION PRIVILEGE

If, as a Covered Individual, your Group Medical Coverage under this Plan terminates and you waived your COBRA Coverage Continuation Privilege **or** that privilege has run-out, then you may be eligible to convert your coverage to an Individual Health Policy offered and issued by the Plan's Carrier. You must make application within thirty-one (31) days from the date your group coverage terminates or your COBRA continued coverage terminates under the Plan. The Plan should be notified immediately as to an individual's interest or desire to convert coverage. Information regarding benefits, cost, application and eligibility for such individual policy will be provided by the Carrier upon notification and request by the Plan on your behalf. ***[This privilege does NOT apply to Dental Coverage or the ScripCard Prescription Drug Benefit]***

SCHEDULE OF MEDICAL & DENTAL BENEFITS

If, while covered under this Plan, an individual receives Health Services due to Illness or Injury or receives Dental Services, the Plan, upon receiving proof of such incurred services, will pay benefits according to this Schedule and subject to the provisions, maximum payments, limitations, exclusions and qualifications specified in this Plan.

MEDICAL & DENTAL BENEFITS BEFORE DEDUCTIBLE

Prescription Drug Benefit [Co-Pay Then Paid @ 100%]	ScripCard Pharmacies PPO	ScripCard Pharmacies Non-PPO
o Brand Name Drug	$10 Co-Pay	$13 Co-Pay
o Generic Drug	$ 5 Co-Pay	$ 6 Co-Pay
Supplemental Accident Benefit	Paid @ 100%	
Dental Benefits		
o Diagnostic, Preventive, Basic Restorative, & Periodontic Services	Paid @ 100%	
o Major Prosthetic Services	Paid @ 50%	

	OPTION I	OPTION II
BENEFIT PERIOD MEDICAL DEDUCTIBLE		
o Per Covered Individual	$ 200	$ 500
o Maximum Per Family	$ 400	$ 1,000
MEDICAL BENEFITS AFTER DEDUCTIBLE		
Mental/Nervous & Chemical Dependency - Outpatient Treatment		
o After Deductible, First $ 100	Paid @ 100%	
o Next $ 100	Paid @ 80%	
o Next $ 1,640	Paid @ 50%	

Mental/Nervous & Chemical Dependency - Inpatient Treatment		
o First 60 Days/Benefit Period	Same as **ALL** Other Covered Medical Services	
o The 61st thru 120th Day/Benefit Period	Paid @ 50%	
	OPTION I	**OPTION II**
ALL Other Covered Medical Services		
o Per Covered Individual	Next $ 1,000 Paid @ 80%	Next $ 2,000 Paid @ 80%
o Maximum Per Family	Next $ 2,000 Paid @ 80%	Next $ 4,000 Paid @ 80%
o Thereafter per Benefit Period	Paid @ 100%	Paid @ 100%

NOTE: AN INPATIENT STAY MUST BE PRE-AUTHORIZED BY CAREREVIEW 48 HOURS PRIOR TO ADMISSION. IF THERE IS AN EMERGENCY ADMISSION, CAREREVIEW MUST CERTIFY THE CONFINEMENT BY THE LATER OF 48 HOURS OR THE NEXT BUSINESS DAY FOLLOWING ADMISSION. **IF THESE PROCEDURES ARE NOT FOLLOWED, ELIGIBLE HOSPITAL EXPENSES WILL BE REDUCED BY $200 PER CONFINEMENT.**

BENEFIT LIMITATIONS

Inpatient Room & Board	Semi-Private Room Rate Allowed.
Intensive/Coronary Care Unit	Usual & Customary Charge Allowed.
Mental/Nervous & Chemical Dependency Treatment	Maximum per Benefit Period:
o Inpatient	120 Days. Limited to one routine visit or psychiatric service per day.
o Outpatient	$ 1,000 (Payable per Schedule above)
Prescription Drugs	Payable based on the greater of a 34-Day or 100-Unit Supply per Prescription. Includes a 3-Month Cycle Supply for Oral Contraceptives.

Temporomandibular Joint Dysfunction (TMJ)	Surgery & the related Hospital services are covered as any other Illness. All other medical services limited to Lifetime Maximum Benefit of $ 1,000.
MENTAL/NERVOUS AND CHEMICAL DEPENDENCY BENEFITS - OUTPATIENT	$ 7,500 LIFETIME MAXIMUM
ALL PLAN BENEFITS COMBINED	$ 2,000,000 LIFETIME MAXIMUM

Eligible Employees	**Full-Time:** Instructors who work a minimum of 9 months and 177 Contract Days. Administration Employees who regularly work 40 or more hours per week. Classified Employee, regularly works 40 or more hours per week. Program/Technical Employee, regularly works 40 or more hours per week. **Part-Time:** Instructors who work less than 177 Contract Days. Administration Employees who regularly works less than 40 hours per week. **Retirees:** An Employee who has been employed by the Employer; becomes retired from service or disabled; and is receiving retirement or disability benefits for service with the Employer.
Waiting Period	From Hire or Start Date of full-time or part-time employment to the end of the month. (Does not apply to Employees hired on the first of the month)
Eligibility Date	Next day following the completion of the Waiting Period. If hired on the first day of the month, than eligibility date becomes the date of hire.
Effective Date of Coverage	Eligibility Date if enrolled within 30 days thereafter.

MEDICAL & DENTAL COVERAGE DEFINITIONS

ALTERNATIVE CARE: A course of medical treatment or care which is determined by the patient's Physician to be both Medically Necessary and an alternative to the treatment currently being rendered. Such treatment is subject to Plan approval as it relates to determining if the alternative services are to be covered under the Plan.

BENEFIT PERIOD: The Benefit Period will be the twelve month period commencing July 1 and ending June 30 of the succeeding Calendar Year.

CAREREVIEW: The provider of Pre-Authorization and Continued Stay Review services for Inpatient Hospital Confinements for the Plan's Pre-Admission Certification Program.

CLOSE RELATIVE: A Covered Individual's spouse, parent, sibling, child, grandparent or in-law.

CO-INSURANCE: Is that portion of Eligible Expense which is **not** paid by the Plan and, therefore, the responsibility of the Covered Individual. For example, when the Plan pays Benefits at 80% (of the Eligible Expense), the Covered Individual is responsible to pay for 20% of all such expenses. **Excludes** charges for services which are not covered by the Plan or are in excess of the Eligible Expense. All such charges are the responsibility of the Covered Individual.

CO-PAY: That portion of the Eligible Expense for an incurred covered medical service which is the responsibility of the Covered Individual. The amount indicated in the Schedule of Medical Benefits will reduce the Eligible Expense accordingly in order for the Plan to apply and pay its portion as indicated by a percentage. A Co-Pay is applied for each occurrence of such covered medical service **and** is **NOT** applied toward satisfaction of the Deductible or Co-Insurance.

CUSTODIAL CARE: Care which is primarily intended to assist an individual in meeting the activities of daily living as defined by the Medicare Guidelines and determined by the Plan and/or its Medical Consultant(s). The care is of a nature that does not require the continued attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to: assistance in walking or getting in and out of bed; bathing, dressing or feeding; preparation of special diets; or supervision of medication which can normally be self-administered.

DEDUCTIBLE: The total amount of Eligible Medical or Dental Expenses, as indicated in the Schedule of Medical & Dental Benefits (for each Plan Option available) which must be incurred by the Covered Individual due to Illness or Injury or receipt of Dental Services during any **Benefit Period** before covered medical and dental services are payable under the Plan. The Deductible **Maximum per Family**, as indicated in the Schedule of Medical Benefits, is the maximum amount of individual deductibles which must be incurred by the Covered Family Members before Medical Benefits are payable for all Covered Family Members under the Plan.

Commencing with the Benefit Period which begins July 1, 1992 and for each Benefit Period thereafter, there will be a **Deductible Carryover** which provides that if, during the last three months of Benefit Period, a Covered Individual incurs Eligible Expenses which are applicable to that Benefit Period Deductible, those same expenses will also be applied to the Deductible for the next succeeding Benefit Period.

DENTAL HYGIENIST: A person who is duly licensed to practice Dental Hygiene by and qualified under the laws of the State in which his services are rendered **provided** such hygienist works for and under the supervision and direction of a Dentist.

DENTIST: Any Doctor of Medicine (MD), Dental Surgery (DDS) or Dental Medicine and Dental Hygienists for covered dental services which they personally perform. The Dentist must be duly licensed and qualified under the laws of the State in which such covered services are performed.

DURABLE MEDICAL EQUIPMENT: Equipment which is: able to withstand repeated use; primarily and customarily used to serve a medical purpose; and not generally useful to an individual in the absence of an Illness or Injury.

ELIGIBLE EXPENSE: The medical and dental services covered under the Plan are subject to the Usual & Customary Charge criteria and the inpatient Room and Board services covered under the Plan are subject to the Semi-Private Room Rate criteria when determining the allowable amount to which Medical and Dental Benefits are applied and paid.

HOSPITAL: An institution that is established and licensed as a Hospital by the State in which it is located and is operated in accordance with the laws pertaining to such licensure. The institution must be primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick persons on an inpatient basis and for compensation. The institution must also be operated by or under the supervision of a staff of duly licensed Physicians and continuously provide 24-Hour a day nursing service by or under the supervision of licensed Registered Nurses.

The following facilities, when duly licensed and operated under the laws of the State in which services are performed, will also be considered a Hospital:

A. A RESIDENTIAL MENTAL HEALTH FACILITY for the treatment of Emotionally Handicapped Children or PSYCHIATRIC HOSPITAL for the treatment of Mental Illness or Nervous Disorder.

B. A RESIDENTIAL CHEMICAL DEPENDENCY TREATMENT FACILITY for the treatment of Alcoholism, Chemical Dependency or Drug Addiction.

C. A FREESTANDING AMBULATORY or OUTPATIENT SURGICAL CENTER. Includes a BIRTHING CENTER.

D. A FREESTANDING AMBULATORY MEDICAL CENTER.

The term Hospital does **not** include an institution which is primarily a nursing or rest home, a place for the aged, or a clinic. It also does not include a facility which: is operated by one or more Physicians solely for their own patients; exists for the primary purpose of terminating pregnancies; and/or merely provides overnight accommodations.

ILLNESS: A disease, sickness, Pregnancy or a condition involving bodily or mental disorder of any kind. All bodily disorders which exist simultaneously and are due to the same or related causes shall be considered one Illness.

INJURY: A bodily injury or injuries which results independently of Illness and is caused by accidental means. All bodily injuries sustained in any one accident and/or all related conditions and recurrent symptoms will be considered one Injury.

LIFETIME MAXIMUM: As used herein, refers to the maximum benefit payable during an individual's life while covered under this Plan. Benefits are available only when an individual is eligible for coverage and becomes and remains covered under this Plan. The Plan provides for a Lifetime Maximum Benefit for specific types of medical treatment as well as for the total benefits provided by the Plan as indicated in the Schedule of Medical & Dental Benefits. When a Lifetime Maximum Benefit for a Covered Individual has been fully paid under the Plan, the coverage for those benefits will terminate under the Plan.

LICENSED PRACTICAL NURSE: An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

MEDICALLY NECESSARY: Health care services, supplies or treatments which, in the judgement of the attending Physician, are appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

MENTAL ILLNESS/NERVOUS DISORDER: A condition which is defined as such in the "International Classification of Diseases Adapted" under 9 Section V - Mental Disorders.

PHYSICIAN: Any Doctor of Medicine (MD) or Osteopathy (DO) and also includes the following health professionals for covered medical services which they personally render: Chiropractors, Dentists (DDS), Licensed Consulting Psychologists, Licensed Psychologists, Occupational Therapists, Optometrists, Physical Therapists, Podiatrists and licensed Registered Nurses (RN) certified as a: Nurse Midwife, Nurse Anesthetist, Nurse Practitioner, Clinical Specialist in Psychiatric or Mental Health Nursing, Speech Therapists, and Speech Pathologists. Employees of a Doctor of Medicine or Osteopathy who provide services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan. The Physician, who customarily charges for his services, must be duly licensed and qualified under the laws of the State in which he performs the covered medical services.

PRESCRIPTION: Is the Physician's written order with regard to dispensing a drug, health supply or medication; or a written directive for the dispensing of a patient's medical treatment, diagnostic tests or care.

PRESCRIPTION DRUG: A drug or biological obtained **only** by a Prescription and is covered under the Federal Food, Drug and Cosmetic Act; or a compound drug, biological or medication required by the State laws or statutes where dispensed to require a Prescription by a health professional who is authorized by law to prescribe such drug. Prescription Drugs will include insulin and **exclude** any drug not approved for sale by the Federal Food & Drug Administration.

PROVIDER: An institution, organization or individual that furnishes covered Health Services either directly or pursuant to a Prescription from an individual licensed to make such Prescription by the State in which services are rendered. The health professional who personally provides covered medical services pursuant to a Prescription must also be duly licensed and qualified under the laws of the State in which the services are rendered.

PSYCHIATRIC CARE: The treatment of a mental illness or disorder, a functional nervous disorder, alcoholism or drug addiction. (Also known as psychoanalytic care.)

REGISTERED NURSE: An individual who has received specialized nursing training and is authorized to use the designation of "RN" and is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

SINGLE PROCEDURE: With reference to Dental Coverage, means a dental service to which a separate procedure code is assigned by the Plan.

SUCCESSIVE PERIODS OF HOSPITAL CONFINEMENT: With respect to a Covered Employee, successive periods of hospital confinement for the same or related causes shall be considered one period of confinement unless the subsequent confinement commences after return to active work on a full-time basis for a period of two weeks. Successive periods of hospital confinement due to entirely unrelated causes shall be considered one period of confinement unless the subsequent confinement commences after return to active work on a full-time basis for one day. For a dependent, successive periods of hospital confinement will be considered one period of confinement unless the subsequent confinement commences after three months have elapsed following prior confinement.

SURGERY: Any operative or diagnostic procedure performed in the treatment of an Illness or Injury by an instrument or cutting procedure through any natural body opening or incision.

USUAL & CUSTOMARY CHARGE: Charges made for medical or dental services or supplies essential to the medical or dental care of the individual will be subject to a Usual & Customary fee. Usual and Customary means the amount normally charged by the provider for similar services and supplies which do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the same geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical complications or unusual circumstances which require additional time, skill or experience.

ELIGIBLE MEDICAL EXPENSES

Medical services which are ordered or performed by a Physician for Medically Necessary care, treatment, consultation, and diagnosis of an Illness or Injury and provided to a Covered Individual will be deemed to be Eligible Medical Expense under the Plan as indicated herein. All such expenses are payable according to the Schedule of Medical & Dental Benefits and subject to all provisions, exceptions, limitations, exclusions and qualifications specified in the Plan.

1. **Hospital Room and Board** for Inpatient Hospital Stays. Includes all regular daily services for a semi-private room (two or more beds). The extensive acute medical services of an Intensive, Coronary or Burn Care Unit are covered up to the Usual & Customary Charge for such services. If you use a private room, you will be responsible for the difference between the semi-private and private room rates. There is no restriction on the hospital days allowed for general admissions.

2. All other **Miscellaneous Hospital Services** for necessary medical care and treatment as an Inpatient (while confined) or Outpatient. Excludes professional services.

3. **Surgery & Anesthesiology**. Surgical services include treatment of fractures and dislocations, biopsies, aspirations and endoscopic procedures. Anesthesiology services includes the cost of the anesthetic and its professional administration.

4. **Physician Services** for medical care and treatment. Includes office visits, allergy testing and treatment, immunizations and vaccinations, and professional nursing services provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Private duty nursing by an RN or LPN is covered up to a Maximum Benefit of $ 1,500 per Covered Individual and $ 3,000 per Covered Family for each Benefit Period. A Consultation provided to a Covered Individual while Hospital confined for a medical condition which requires special skill or knowledge in diagnosis or treatment will be covered for one consultation per admission.

5. **Physical Therapy Modalities**. Includes physical, occupational, speech or respiratory therapy; and cardiac or pulmonary rehabilitation.

6. **Drugs and Medicines** prescribed by a Physician and dispensed by a licensed pharmacist which are deemed necessary for recovery or for sustaining life and any legend drug (requires a prescription by State or Federal law) including insulin and oral contraceptives except those items listed under "exclusions" of this plan. The Co-Pay only applies to Prescription Drugs which are limited to the greater of a 34-Day or 100-

Unit Supply or a 3-month cycle supply for oral contraceptives. All other eligible expenses which include blood, blood plasma or derivatives, supplies for drug administration or medical applications, are payable the same as any other Illness. See "Schedule of Benefits" for co-pay amounts.

7. Casts, splints, trusses, braces, crutches, artificial limbs, artificial eyes, and the rental of oxygen equipment, wheelchairs, special hospital beds, iron lungs, and **Durable Medical Equipment** necessary for the treatment of the patient.

   a. The rental of other mechanical equipment may be interpreted to include oxygen, walkers, whirlpool attachments, portable humidifiers, etc., which are prescribed by a qualified Physician for the treatment of an Illness or Injury. Specifically **excluded** from coverage are expenses incurred for the rental of any type of air conditioner, air purifier, therapeutic mattress, or any other device or appliance.

   b. When the extended use of eligible rental equipment is deemed necessary for the treatment of the Covered Individual, the Plan Administrator shall be solely responsible for determining, in a non-discriminatory manner, when provisions of the Plan permit the purchase of such equipment.

8. Commercial ground or air **Ambulance Service** to transport the Covered Individual to and from the Hospital in an emergency situation when medically necessary. Limited to 500 mile radius.

9. Medically necessary **X-Ray & Laboratory Tests and Examinations** when requested by the attending Physician. Includes diagnostic, radiation therapy, and isotope studies.

10. **Cosmetic Surgery or Treatment** by a Physician for injuries resulting from an accident which occurred while covered under the Plan or for surgery to correct a congenital anomaly provided the Covered Individual was covered at birth.

11. Expenses for **Mental/Nervous Disorders** are covered as stated in the Schedule of Medical & Dental Benefits. Inpatient services must be rendered by a Hospital. Outpatient services must be provided by a Medical Doctor (MD), Psychiatrist, Licensed Consulting Psychologist, Licensed Psychologist, Specialist Clinical Social Worker, or be received at a Mental Health Clinic licensed by the State in which it is located. Includes expenses incurred for the treatment of an **Emotionally Handicapped Dependent Child** in a Residential Treatment Center.

12. Expenses for **Alcoholism or Chemical Dependency**, are covered as stated in the Schedule of Medical & Dental Benefits. Inpatient services must be rendered by a Hospital. Outpatient services must be provided by a Medical Doctor (MD), Psychiatrist, Licensed Consulting Psychologist or a Non-Residential Treatment or Counseling Program which is licensed by the state in which it is located to provide chemical dependency treatment. A treatment program must be completed in order to receive Inpatient benefits under the Plan.

13. Expenses in connection with **Miscarriage or Pregnancy** are covered as any other Illness.

14. **Routine Newborn Hospital Care** will be considered services incurred by the child and will be an eligible expense if the newborn is a covered individual.

15. **Pregnancy and Routine Newborn Hospital Care for adoptive children** will be considered covered expenses if the child is adopted/placed with the Employee/Retiree for the purpose of legal adoption within 31 days of birth.

16. **Chiropractic Treatment** and services which relate to the spine, muscles or joints.

17. Expenses for **Outpatient Pre-Admission Tests** which are incurred immediately prior to (within 7 days) a scheduled Inpatient Hospital Confinement or Surgery.

18. Expenses incurred for **Sterilization** will be eligible under the Plan.

19. Surgery and the related Hospital expenses for the treatment of **Temporomandibular Joint Dysfunction (TMJ)**. Other unspecified medical services or treatment will be limited to a Lifetime Maximum Benefit of $ 1,000.

20. Services and supplies in connection with **Surgical Transplant Procedures**, subject to the following conditions:

   a. A second opinion must be obtained prior to undergoing any transplant procedure. This mandatory second opinion must concur with the attending physician's findings regarding the medical necessity of such procedure. The physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the physician who will be performing the actual surgery.

b. The transplant donor who incurs eligible medical expenses, will be covered under this Plan **unless** the donor is covered under his own plan.

c. When the transplant recipient is covered under this Plan, eligible medical expenses will be payable for Benefits under the Plan.

d. When eligible medical expenses are covered under this Plan for both the Transplant donor and recipient, each individual is considered separately with regard to the payment of Benefits.

e. The reasonable and customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a hospital's charge for storage or transportation of the organ, will be considered a covered expense.

Such Transplant procedures include but is not limited to a human heart, heart-lung, liver and Kidney in addition to other human tissue and organ transplants deemed not to be Experimental or Investigative.

21. Expenses for one **Routine Eye Examination** per Benefit Period. Includes refraction. Eye Examinations which are medically necessary are covered as any other eligible medical expenses.

22. **Dental services** rendered by a physician, dentist or dental surgeon for the treatment of fractured jaw or accidental injuries to sound, natural teeth while covered under the plan. Treatment for the accident includes the replacement of sound, natural teeth and expenses for hospital room and board and other specific hospital services while a registered bed patient when medically necessary. Surgical removal of impacted teeth is an eligible expense.

23. Expenses for **routine physical examinations**, limited to one per calendar year.

24. Expenses for one **prostate exam, mammogram, pap smear and hemmocult** per calendar year, including an office visit.

25. Expenses for **well baby care** up to age 2, including vaccinations and inoculations.

ELIGIBLE DENTAL EXPENSES

Dental services which are performed or supervised by a Dentist for necessary dental care and treatment and provided to a Covered Individual will be deemed to be Eligible Dental Expense under the Plan as indicated herein. All such expenses are payable according to the Schedule of Medical & Dental Benefits and subject to all provisions, exceptions, limitations, exclusions and qualifications specified in the Plan.

1. **Preventive & Diagnostic Services** are payable as **ALL** Other Covered Services and encompasses the following.

   A. Initial, Periodic or Diagnostic Oral Examinations.

   B. Prophylaxis & Topical Applications. Includes teeth cleaning, scaling, and polishing; and topical fluoride application for covered individual until the end of the month in which such individual reaches Age 23.

   C. Dental X-Rays. Includes routine and preventive x-rays and those required to treat or diagnose diseases or abnormalities of the teeth, surrounding tissue and cavity detection.

   D. Repairs & Adjustments to Prosthetic Devices (Dentures or Bridges) and related services.

   E. Emergency Palliative Treatment to temporarily relieve acute dental pain. Excludes treatment which exceeds palliative services. (Actual restorative work was performed such as a permanent filling or temporary crown.)

2. **Basic Restorative Services** are payable as **ALL** Other Covered Services and encompasses the following:

   A. Fillings. Excludes gold.

   B. Simple Extractions.

   C. General Anesthesia when the dental treatment is a covered service.

   D. Endodontic Services. Includes pulpotomy, pulp capping, and root canal treatment.

   E. Periodontic Services. Includes gingiva and osseous (Bone) surgery or surgery of the bony structure supporting the teeth; periodontic scaling and root planing; and any non-surgical care of acute oral infection and oral lesions.

3. **Major Prosthetic Services** are payable per the Schedule of Medical & Dental Benefits @ 50% of the Usual & Customary Charge and encompasses the following and Services of D, E and F are subject to the **Dental Benefit Waiting Period:**

   A. Space Maintainers

   B. Oral Surgery which consists of: diagnosis and treatment of fractures, dislocations, cysts and abscesses; and surgical extractions (beyond simple extractions and includes impacted teeth).

   C. Apicoectomy (removal of a root tip).

   D. Inlays, Onlays or Crowns (not part of a Bridge).

   E. Bridges, Removable or Fixed. Includes crowns which are part of the Bridge.

   F. Dentures, Full or Partial.

PLAN EXCLUSIONS & LIMITATIONS

The following items of expense are excluded under this Plan.

1. Medical & Dental Expenses incurred for the treatment of Accidental Injury or Illness which arises out of or in the course of any occupation for wage or profit for which the covered individual is entitled to benefits under any **Worker's Compensation Law**, occupational disease law or similar legislation.

2. Expenses charged by a Hospital or Residential Treatment Center for inpatient services which are not **Recommended or Approved by a Physician**.

3. Expenses incurred by an individual **PRIOR** to his Effective Date of Coverage or **AFTER** his Termination Date of Coverage under the Plan.

4. Expenses for Pre-Existing Conditions for new hires and late enrollees. A Pre-Existing Condition is defined as an Illness or Injury for which medical care, diagnosis, consultation, advice or a prescription drug has been received during the **three (3)** consecutive month period prior to the effective date of coverage under this Plan. Pre-Existing Conditions will be covered after the end of:

   a. **Three (3)** consecutive months during which the Covered Person has been continuously covered under the Plan and has not received any medical care, diagnosis, consultation, advice or prescription drugs relating to the Pre-Existing Condition; or

   b. **Twelve (12)** consecutive months during which the Covered Person has been continuously covered under this Plan.

5. Expenses incurred for **Vision Care & Hearing Aid Services** which includes eye refractions, eyeglasses (lenses, frames, or contact lenses) and other fabricated optical devices, and hearing aids and examinations for the fitting of them. **Except** for one Eye Examination (and refraction) per Benefit Period as provided for under the Eligible Medical Expenses.

6. **Cosmetic Surgery. Except** services incurred: to repair a defect caused by an Injury which occurs while the individual is covered under the Plan or to repair a Covered Dependent Child's congenital anomaly provided the child was covered under the Plan at birth. Excluded Cosmetic Surgery will also encompass any expenses incurred which results from or is related to any operation, treatment, psychiatric service or counseling for the purpose of sexual transformation of the covered individual.

7. Services, care and supplies which are not medically recognized or are deemed to be **Experimental or Investigational Procedures.** Medically Recognized means procedures which are acceptable and deemed to be proven medical practices by the Plan and its Medical Consultant(s). (Including, but not limited to the American Medical Association).

8. Expenses incurred for confinement, medical or dental treatment, care or service that is paid for or **Furnished by the United States Government** or one of its agencies (except as required under Medicaid provisions or federal law), or by a state or local government agency, unless charges are imposed against the covered individual for such confinement, treatment, or service.

9. Medical or Dental Expenses incurred due to an Accidental Injury or Illness **resulting from war** or any act of war, declared or undeclared, or while in the armed forces of any country or international organization.

10. Medical or Dental Expenses incurred due to an Accidental Injury or Illness occurring while in the **Act of Committing a Felony.**

11. Medical or Dental Expenses incurred which would be eligible for payment under any plan or **Policy Required by Law**, whether the covered individual chose to be covered under such plan or not. Under required No-Fault Auto coverage, the minimum coverage required by law will be treated as an additional deductible.

12. Medical or Dental Expenses incurred for treatment for which the covered person is eligible for benefits under **Other Group Insurance Plan(s)** through any other employer; or under any group service-type (Blue Cross-Blue Shield), union welfare, other employee benefit plan (see Coordination of Benefits section), or medical or dental payment or personal injury sections of automobile insurance, casualty or liability insurance regardless of whether such policy is owned by the covered person or some other party (see Subrogation section).

13. Any treatment or expense, that in the opinion of the Plan and its Medical Consultant(s), becomes **Elective or Custodial** during the course of treatment and is not necessary for commonly accepted medical reasons.

14. Medical or Dental Expenses for services which are furnished under conditions which the covered individual has **No Legal Obligation to Pay**, or if the expenses are reimbursable by any local or other governmental agency. This exclusion will not apply to eligible expenses which may be covered by state Medicaid coverage where federal law requires this employer's plan to be primary.

15. Expenses, services, care and supplies provided by a **Close Relative.**

16. Expenses incurred which are in excess of the **Usual and Customary Charge** allowed.

17. Expenses for treatment if the Covered Individual **leaves** the **United States, U.S. Territories or Canada** for the express purpose of receiving medical treatment. However, if the Covered Individual is outside of this area for other reasons, coverage will be available for the first 120 Days while out of the area. This time limit will not apply if the Covered Individual is out of the area on business for the Employer or as a full-time student.

18. **Contraceptive Devices** or expenses for the surgical reversal of a previous elective sterilization.

19. Expenses for inpatient confinement, treatment, testing or services related to **Fertility** or the **Promotion of Conception.**

20. Inpatient confinement, treatment or services for **Educational or Training Problems,** learning disorders, developmental delay, unless due to Illness or Injury.

21. Expenses incurred for the treatment of **Obesity**, except for morbid obesity.

22. Expenses incurred due to Illness or Injury resulting from **Attempted Suicide**, while sane or insane, or from intentional self-inflicted injury or bodily harm.

23. Expenses incurred for **Radial Keratotomies.**

24. Expenses for **Personal Items.**

25. Expenses incurred in connection with **Acupuncture** or the admissions of acupuncture.

26. Expenses incurred for the treatment of **Sexual Misfunctions** or inadequacies. **Except** the Plan will cover a penile prosthesis required for physiological impotence when due to trauma, radical pelvic surgery, Peyronie's Disease, vascular or neurological diseases when the individual situation warrants coverage in the Plan's opinion.

27. Expenses for **Corrective Shoes** and other items of wearing apparel.

28. Expenses incurred for an **Elective Abortion.**

29. Expenses for **routine physical examinations** in excess of the amount indicated under "Eligible Medical Expenses".

30. Expenses incurred for **Convalescent or Custodial Care** or rest cures.

31. Expenses for **drugs, medications, implements and or health care devices** that are NOT COVERED under the ScripCard program are:

    a) All over the counter medication (OTC's)
    b) Diabetic supplies
    c) Medical devices
    d) Contraceptive devices, IUD's and diaphragms.
    e) Aids related drugs
    f) Vitamins if OTC
    g) Chemotherapy for malignant conditions
    h) Investigational or experimental drugs
    i) Charges covered by any Worker's Compensation law, employer's liability or occupational disease law.
    j) Medication which is to be taken by or administered to an individual while in a hospital, rest home, sanatarium, extended care facility, convalescent or nursing home.
    k) Drugs covered by any other prescription program.
    l) Prescription drugs obtained for use in connection with drug addiction.

See "Schedule of Benefits" for Co-pay information.

DENTAL EXCLUSIONS & LIMITATIONS

In addition to the Plan Exclusions & Limitations above, the following dental services will also be excluded under the Plan:

1. Dental services or supplies which do not meet accepted standards of dental practice as adopted and accepted by the American Dental Association (ADA), including charges for services and supplies which are experimental in nature; this provision also limits coverage to standard techniques and **excludes** specialized techniques.

2. Dental services provided primarily for **Cosmetic** purposes **except** following an accidental Injury that occurred while the individual was covered under this Plan.

3. Dental Services for which the Covered Individual incurs no charge.

4. Charges for failure to keep a scheduled dental office appointment.

5. Charges for the completion of any insurance or claim forms.

6. Charges for the upgrading of serviceable dentistry.

7. Charges for the replacement of lost or stolen dentures, bridges or prosthetic devices.

8. Charges for duplicate prosthetic devices or the replacement of dentures, bridges or prosthetic devices less than five years old.

9. Services performed or incurred before the Effective Date of the individual's coverage under this Plan. A Dental Service is deemed to be incurred on the date such service or supply is rendered or received **except with respect to:**

    a. **Dentures or Fixed Bridges** - service is deemed to be incurred on the date the impression is taken;

    b. **Crowns** - service is deemed to be incurred on the date preparation of the tooth commenced; and

    c. **Root Canal Therapy** - service is deemed to be incurred on the date work commences on the tooth and the pulp chamber is open.

10. Charges made for dental services performed after the termination date of the individual's coverage under the Plan **except** for services performed within one month of such termination date which are needed to complete a Single Procedure which commenced on or before the termination date.

11. Charges made for dental treatment or services in excess of the Usual & Customary Charge.

12. Charges for tooth implants, myofunctional therapy, or mouth guards.

13. Charges for training and counseling in Oral Hygiene, Dietary or Plaque Control or other educational programs.

14. Charges for gold foil restorations.

15. Charges for orthodontic examination, care, treatment or appliances.

16. Charges incurred by a "Late Enrollee" prior to the expiration of the Benefit Waiting Period.

17. Charges incurred for Inlays, Onlays, or Crowns (not part of a bridge); Bridges (removable or fixed) and Dentures (full or partial) prior to the expiration of the Benefit Waiting Period. **Except** when such services are incurred as a result of an accidental Injury or oral surgery (involving the removal of a foreign body or repositioning of muscle attachments) which occurs while covered under this Plan, in which case, the Benefit Waiting Period is waived.

18. Where there are alternate courses of treatment available which carry different charges, the Plan will provide benefits for the least expensive service or supply which conforms to acceptable dental standards and practice.

19. Charges for Dental Services other than those listed under "Eligible Dental Expenses".

20. Charges for a Temporary Prosthetic Device or for adjustment or relining of a prosthetic device when rendered prior to 6 months from the date such prosthetic device was initially furnished.

CareReview® Inpatient Pre-Admission Certification Program

If a Covered Individual is admitted or is recommended by a Physician to be admitted to a Hospital as an In-patient, the confinement must be pre-certified by CareReview®. CareReview® will provide administrative services for the Pre-certification/Continued Stay Review.

For a non-emergency hospitalization, CareReview® will evaluate the proposed admission plan and length of stay based on CareReview® 's Physician Developed Criteria (PDC) for medical care. Then CareReview® will notify your doctor in writing, specifying the date that CareReview® believes that the physician should discharge the patient according to the information given by the attending physician.

Benefits will only be available for the number of days that have been certified. If the confinement will last longer than the number of days certified, your doctor must call CareReview® before those extra days begin and obtain authorization for the additional time. If the additional days are not requested and authorized, you may receive a reduced benefit.

If a hospital admission is caused by a sudden onset of a medical condition and the patient, patient's family, hospital staff or attending physician are unable to contact CareReview® prior to the admission, CareReview® must be contacted within 48 hours of the admission. (If emergency admission occurs on a weekend or holiday, CareReview® notification can be extended to the first business day following the emergency admission.)

If the patient is unconscious, in a coma, or unable to contact CareReview® due to illness or injury rendering the patient physically or mentally incapable, the notification requirement will be waived until the patient is able to contact CareReview®. Certification will be retroactive to the date of admission.

If these procedures are not followed, eligible Hospital expenses will be reduced by $200 per confinement.

CareReview® pre-admission reviews do not guarantee payments. All payments are subject to the Claims Administrator's determination of eligibility (Employee/dependents/employer eligibility) and payments of premiums and coverage (medical necessity, pre-existing, UCR, etc.) at the time the services are rendered.

COORDINATION OF BENEFITS (COB)

DUPLICATION OF COVERAGE LIMITATION

If a Covered Individual is also covered or insured under any other group plan, including Medicare, the total services rendered to any one person or the total payment received for any one person from all programs combined, may not amount to more than 100% of the Allowable Expenses. Services and benefits are reduced only to the extent necessary to prevent an individual from making a profit on his Health and Dental Coverage or Insurance. An Employee must report **Duplicate Group Health or Dental Coverage** on the Statement of Claim he submits to secure reimbursement or to authorize payment of hospital, medical, surgical and dental expenses.

ALLOWABLE EXPENSES: Any necessary and reasonable health services or reasonable expenses for medical or dental treatment or supplies covered by one of the plans under which the individual is covered or insured. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service will be deemed to be both an Allowable Expense and a Benefit Paid.

PLAN: As used here, means any plan providing benefits or services for or by reason of medical or dental care or treatment which benefits or services are provided by:

a. Groups, blanket or franchise coverage;

b. Blue Cross, Blue Shield, Group Practice, Individual Practice or other payment coverage;

c. Any coverage under Labor-Management Trusteed Plans, Union Welfare Plans, Employer Organization Plans or Employee Benefit Organization Plans;

d. Any coverage under Governmental Programs or required or provided by statute. Such coverage excludes benefits received under No-Fault Insurance Laws of any State. Such coverage also excludes Welfare Benefits provided by the State, in which case this Plan will furnish benefits first; **and**

e. Any coverage provided through a school or educational institution.

The term **PLAN** shall be construed separately with respect to each policy, contract or other arrangement for benefits or services; and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take benefits or services of other plans into consideration in determining benefits and that portion which does not.

ORDER OF BENEFIT DETERMINATION RULES

When duplicate coverage arises in Plans which: do not have a Coordination of Benefits (COB) Provision **or** use an Order of Benefit Determination Rules that differs from the accepted standards, such plan shall pay or provide their benefits first; and those that use the Standard COB and Order of Benefit Determination Rules will always pay second.

When the Coordinating plans follow the uniform rules, the Order of Benefit Determination will be as follows:

1. **Employee/Dependent** - The plan which covers the Individual as an Employee pays first; while the plan covering the individual as a dependent pays benefits second.

2. **Dependent Children of Parents NOT Separated or Divorced** - The plan covering the parent whose birthday falls earlier in the year pays first; while the plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan which covered the parent longer pays first and the plan which covered the other parent for the shorter time pays second.

3. **Dependent Children of Separated or Divorced Parents** - If parents are separated or divorced the following rules apply:

   a. The plan of the parent with custody pays first;

   b. The plan of the spouse of the parent with custody (the step-parent) pays next; and

   c. The plan of the parent without custody pays last.

   Notwithstanding the above, if there is a Court Order requiring a person to assume financial responsibility for a dependent child's medical, dental or other health care expenses, the plan that covers that person and the child will pay benefits first before all other plans covering the child as a dependent.

4. **Active/Inactive Employees** - The plan covering the individual as an Active Employee (or as that Individual's Dependent) pays benefits first; while the plan which covers such individual as an inactive (laid-off or disabled) or Retired Employee (or as such individual's dependent) pays benefits second. Further, if such Inactive Employee or Dependent is continuing coverage pursuant to the COBRA provision for a Pre-Existing Conditions clause, **then** this Plan will pay benefits first **only** for the Pre-Existing Condition and be the secondary payor for all other Illness or Injury of such covered individual.

5. **Longer/Shorter Length of Service** - If none of the above rules determine the Order of Benefits Payment, the plan which has covered the individual for the longer period of time will pay first and the plan covering the individual the shorter period of time pays second.

RIGHT TO RECEIVE OR RELEASE INFORMATION

For the purpose of determining the applicability of and implementing the terms of this Provision or any provisions of similar purpose of any plan, the Plan Administrator may, without the consent of or notice to the Covered Individual, release to or obtain from any other insurance company or other organization or person, any information with respect to the Covered Individual, which the Plan Administrator deems necessary for such purposes. Any Covered Individual claiming benefits under this Plan shall furnish the Plan Administrator such information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments have been made under any other plan which should have been made under this Plan, the Plan shall have the right to pay over to such a plan the amounts it shall determine to be warranted in order to satisfy the intent of this coordination provision. These amounts so paid will be considered benefits paid under this Plan to the extent that they are applied toward Maximum Benefits, and the Plan shall be fully discharged of its liability.

RIGHT OF RECOVERY

If, at any time, the Plan has made payments in excess of the maximum amount of payment necessary to satisfy the intent of this provision, the Plan shall have the **Right to Recover** such excess payment. The Plan shall determine where such excess payment will be recovered from among one or more of the following: any person for whom or to whom such payments were made; any insurance company; or any other organization(s) or person(s).

BENEFIT CLAIM PROVISIONS

BENEFITS: If a Covered Individual sustains an Injury or contracts an Illness or incurs Dental Expenses, the Plan agrees to pay the percentages indicated in the "Schedule of Medical & Dental Benefits" for the Eligible Expenses incurred for covered Medical & Dental services subject to the Lifetime Maximum Benefits, limitations, specifications, exclusions and provisions of the Plan.

PROOF OF CLAIM: Written proof of claim for Medical and Dental Services incurred must be furnished to the Plan by the Covered Individual within ninety (90) days after the date such claim is incurred. Failure to furnish proof within this time will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, **provided** the proof is furnished as soon as reasonably possible and, in no event, later than one year from the date such claim is incurred.

Written proof will be satisfied when the Covered Employee submits itemized bills to the Claims Administrator.

An itemized bill must indicate: the Covered Employee's name and Social Security number; the patient's name and diagnosis; the Provider's name and address; and list for **each** Health Service provided: the type of service or supply, date incurred, and charge (cost). A Health Service is considered as incurred on the date the service or supplies are rendered or received.

TIMELINESS OF CLAIM PAYMENT: Amounts payable under this Plan for any claim will be paid within a reasonable period of time after receipt of the due written Proof of Claim.

PAYMENT OF CLAIM: All Benefits will be paid directly to the Provider (**except** for Prescription Drugs) **unless** the Covered Employee provides a written receipt that indicates the amount, date and service(s) and/or supplies being paid; and from whom payment was received.

CLAIM DENIAL & APPEAL PROCEDURE: When a claim for benefits is denied, in whole or in part, the Plan will notify the Covered Individual in writing **and**: indicate the reason for the claim denial; reference the Plan provision(s) applicable to the denial; request information which may allow the Covered Individual to correct the claim for proper processing; and apprise the Covered Individual as to the Claim Review & Appeal Procedures available under the Plan.

APPEAL PROCEDURE

The Appeal Procedure provides for the Covered Individual to file a written request with the Plan Administrator to review a Claim Denial within sixty (60) days after receiving the written notification of denial. The Covered Individual's written appeal should include any information, material or evidence which supports his contention that such claim should be paid by the Plan.

The Plan Administrator will, in turn, review the appeal and provide a written response to the Covered Individual within sixty (60) days of the receipt of the written appeal. The response shall document the specific reasons, with reference to the Plan Provision(s), that the Plan Administrator utilized in making its decision to either concur in or set aside the previous claims disposition.

RECORDS: Each Covered Individual authorizes and directs any provider that has attended, examined or treated him, to furnish the Plan or its representative(s), at any time upon its request, any and all information and records or copies of records relating to the attendance, examination or treatment rendered to him and the Plan or its representative(s) agree that such information and records will be considered confidential. Further, any charges imposed relative to the acquisition of such information will be absorbed by the Covered Employee.

RIGHT TO RECOVER PAYMENTS: Any time the Plan has made benefit payments which are not required as set forth in the terms of this Plan Document, the Plan shall have the Right to Recover such payments from among any of the following: any person for whom or to whom such payments were made; any insurance company; or any other organization(s) or person(s).

SUBROGATION: In the event the Plan pays benefits on behalf of a Covered Individual who has the right to recover these benefits so paid under any other liability or casualty plan (exclusive of any individual disability plan), the Plan shall be subrogated to the extent of the Covered Individual's rights of recovery against any person or entity who may be responsible. The Covered Individual shall execute and deliver instruments and papers, as requested by the Plan, and shall do nothing to prejudice the Plan's right of subrogation. The Plan may initiate an action in the name of the Plan or the Covered Individual to assert its right of subrogation.

The amount of the Plan's subrogated interest shall be deducted first from any recovery by or on behalf of the Covered Individual. The Plan will not be responsible for the Covered Individual's attorneys fees or other costs unless the Plan has agreed in writing to pay such fees or costs.

The Plan Administrator may appoint a third party to manage any necessary non-litigated Subrogation proceedings up to a point when it is determined that an attorney must be hired. The Plan Administrator retains the right to hire and the financial responsibility for an attorney.

GENERAL PLAN PROVISIONS

AMENDMENTS OR TERMINATION: The Plan may be amended (modified) or terminated at any time by the Employer **provided** that such amendment or termination does not affect a Participant's right to Benefits under the Plan which are payable under the Plan Provisions **prior** to any such amendment or termination. The Participants shall be notified in writing by the Plan Administrator with regard to an amendment which significantly impacts the Benefits provided hereunder or upon termination.

APPLICABLE LAW: It is the intent of this Plan to comply with all applicable Federal and State laws. Whenever this Plan is in conflict with a State or Federal Law, the law will prevail over the Plan Provisions. However, if a State Law is in conflict with a Federal Law, the State Law is exempt under Federal Law.

CLAIMS ADMINISTRATOR: The firm or person(s) appointed by the Plan Administrator to be instilled with the responsibility to process claims and pay Benefits in accordance with the Plan provisions as provided in this Plan Document.

EMPLOYEE CONTRIBUTIONS: Any Employee Contributions to this Plan will be immediately applied to stop loss insurance and administrative fees with any excesses being used to pay claims. The Employer determines the amount of Employee Contribution and reserves the right to adjust and modify these amounts. All such contributions are determined on a non-discriminatory basis.

EMPLOYER: The **Dodge City Community College** and the following affiliated and/or subsidiary corporations, firms or associated individuals shall constitute the Employer: None as of the July 1, 1991, the Effective Date of this Plan. With regard to an affiliate (and their Eligible Employees & Dependents) which is added to the Plan, such individuals are not eligible to participate prior to the effective date of addition. An affiliate (and their Covered Employees and Dependents) which terminates participation in the Plan and is no longer affiliated with the Employer ceases to have any rights under the Plan on or after the termination date.

INSPECTION OF PLAN: The Employer, upon request, shall make this Plan Document available for inspection by any Participant in a reasonably accessible place.

INDEMNIFICATION: To the extent permitted by law, the Plan Administrator shall indemnify and hold harmless any person(s) or service firm to whom the Plan Administrator has delegated fiduciary or other duties under the Plan, against any and all claims, losses, damages, expenses and liabilities arising from any act or failure to act that constitutes or is alleged to constitute a breach of such person's or firm's responsibilities in connection with the Plan under ERISA or any other law; unless the same is determined to be due to gross negligence, willful misconduct or willful failure to act. The Participant (the Covered Employee or Covered Dependent) shall hold the Plan Administrator (Employer) harmless against any and all claims, losses or expenses resulting from such person's or firm's involvement in the administration of this Plan.

INTERPRETATION: This Plan is not interpreted as being a contract between the Employer and the Plan Participants.

PARTICIPANT: A Plan Participant is each Employee and Family Dependent who satisfy the Eligibility Provisions of this Plan and voluntarily elects to participate in the Plan in accordance with the Enrollment requirements.

PLAN ADMINISTRATOR: The Employer who sponsors this Welfare Benefit Plan for its Employees. The Plan shall be administered on a uniform and non-discriminatory basis for all Participants. All decisions regarding the administration of this Plan shall be made by the Plan Administrator who may employ, at its sole discretion, any individual or firm for the purpose of instilling certain service responsibilities essential to the day-to-day administration of the Plan.

PRONOUNS: All personal pronouns used in this Plan Document shall include either gender unless the context clearly indicates to the contrary.

STATEMENT OF ERISA RIGHTS

As a participant in the **Dodge City Community College** Employee Medical & Dental Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974.

I. ERISA provides that all plan participants shall be entitled to:

A. Examine, without charge, at the Plan Administrator's Office, all Plan documents. This includes all insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

B. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

C. The Plan Administrator, under certain circumstances, is required to furnish each participant with a copy of the Summary Annual Report.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal Court which may require the Plan Administrator to provide the materials and pay you up to $ 100 a day until you receive the materials **unless** they were not sent because of reasons beyond the control of the Administrator.

II. If your claim for a welfare benefit is denied, in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the Plan review and reconsider your claim. Further, ERISA provides that if your claim is denied or ignored, in whole or in part, you may also file suit in a State or Federal Court.

III. ERISA also imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have the duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal Court.

When you choose to file suit, the Court will decide who should pay court costs and legal fees. If you are successful, the Court may order the person you have sued to pay all of these costs. If you lose, the Court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this Statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration of the Department of Labor.

SUMMARY PLAN DESCRIPTION

Plan Name:	Dodge City Community College Employee Medical & Dental Benefit Plan
Plan Sponsor:	Dodge City Community College 2501 North 14th Avenue Dodge City, Kansas 67801-2399
Employer Federal (EIN) Identification Number;	#52-1718586
Plan Number:	02144
Type of Plan:	The purpose of this Plan is to provide Medical and Dental Coverage to Eligible Employees and their Eligible Dependents who participate in the Plan.
Source of Plan Contributions:	The Employer and Employee
Plan Year:	The first Plan Year will begin July 1, 1991 and end June 30, 1992. Thereafter each Plan Year will begin July 1 and end June 30 in the succeeding Calendar Year.
Claim Procedures:	This is discussed in detail in this Benefit Booklet.
Plan Administrator:	Dodge City Community College 2501 North 14th Avenue Dodge City, Kansas 67801-2399

Claims Administrator:	Western CBSA, Inc. P.O. Box 21040 Denver, CO 80221 (800) 332-7741
Agent for Service of Legal Process:	Dodge City Community College 2501 North 14th Avenue Dodge City, Kansas 67801-2399

Eligibility Requirements, Benefit Descriptions, Circumstances which may cause Disqualification, Ineligibility, Denial, Loss, Forfeiture or Suspension of Benefits - These matters are discussed in detail in this Benefit Booklet.

THIS IS YOUR BENEFIT BOOKLET
READ IT CAREFULLY
KEEP WITH OTHER IMPORTANT DOCUMENTS

Claims Administrator
Corporate Benefit Services of America, Inc.
P.O. Box 21040
Denver, Colorado 80221
1-800-332-7741 • 1-303-427-2802

This Plan has been arranged by:
Intermountain Benefit Administrators
13111 E. Briarwood Ave., Suite 310
Englewood, Colorado 80112
1-303-649-1100